

FILED DEC 12 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36583

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 387 PRIMARY REG. DIST. NO. 4086 Registrar's No. 17

1. PLACE OF DEATH a. COUNTY <u>Carroll</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE <u>Missouri</u> b. COUNTY <u>Carroll</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Tina,</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Tina,</u>	
c. LENGTH OF STAY (In this place) <u>1</u>		d. STREET ADDRESS (If rural, give location) <u>N.W. Part Tina, Mo.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home, Tina, Mo.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>LULA</u>	b. (Middle) <u>Myrtle</u>	c. (Last) <u>DAILEY</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 29, 1949</u>
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5. SEX <u>F ##</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 14, 1879</u>	9. AGE (In years last birthday) <u>70</u>	10 UNDER 1 YEAR	11 UNDER 100 HOURS
				Months <u>4</u>	Days <u>16</u>	Hours <u>0</u> Min. <u>0</u>

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Pittsfield, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>James Wesley Irick</u>	13b. MOTHER'S MAIDEN NAME <u>Dorothy Sharer</u>	14. NAME OF HUSBAND OR WIFE <u>H.J. Dailey</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	(If yes, give war or dates of service) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>H.J. Dailey</u>	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure; ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MYOCARDIAL FAILURE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>  <u>18 mos.</u> <u>1998</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Adeno-CARCINOMA OF Tongue, Jaw, Cervical Lymph Nodes</u>		
	DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from MARCH 10, 1946, to Dec 1, 1949, that I last saw the deceased alive on Nov. 30, 1949, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>R.W. Macklin M.D.</u>	23b. ADDRESS <u>Chillicothe, Missouri</u>	23c. DATE SIGNED <u>12-1-49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>12/2/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Macklin</u>	24d. LOCATION (City, town, or county) (State) <u>Hale Missouri</u>
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DATE REC'D BY LOCAL REG. <u>Dec. 2, 1949</u>	REGISTRAR'S SIGNATURE <u>Mrs Rex Henderson</u>	49	25. FUNERAL DIRECTOR'S SIGNATURE <u>Clifford W. Austin</u>	ADDRESS _____
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

17  
0  
0

City of  
Health Officer

Initial File Number

Date Recd. 12-10-49

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

\_\_\_\_\_ working under my personal supervision.

Student Embalmer No. \_\_\_\_\_

Student \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

*Clifford W. Fuster*

Licensed Embalmer No. #3233.

P. O. Address Tina, Missouri.

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.